STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A DITT	DING	01	COMPL	ETED
		155680	A. BUII B. WIN			09/01/2011	
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER					LEBANON ST		
HOMEWOOD HEALTH CAMPUS			LEBANON, IN46052				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF C		PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		ΤE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K0000							
	A Life Safety Co	ode Recertification	KO	0000	Submission of this plan of corre		
	and State Licen	sure Survey was			does not constitute an admission	-	
	conducted by t	he Indiana State			Homewood Health campus of a wrong-doing or failure to comp	-	
	Department of				with the Federal or State	1y	
	=	h 42 CFR 483.70(a).			Regulations.		
	accordance wit	11 42 CI K 465.70(a).			regulations.		
	5 5 6	0.401.411			Homewood Health Campus sub	mits	
	Survey Date: 0	9/01/11			this plan of correction as its lett	this plan of correction as its letter of	
					credible allegation and is reque	~	
	Facility Numbe	r: 002703			a desk review or a request for a		
	Provider Numb	er: 155680			revisit immediately after Octob	er 1,	
	AIM Number: 2	200309250			2011.		
	Surveyor: Bridg	get Brown Life					
	Safety Code Specialist						
	Safety Code Sp	ecialist					
	At this Life Safe	ety Code survey,					
	Homewood Hea	alth Campus was					
	found not in compliance with						
	Requirements f	or Participation in					
	Medicare/Medi	·					
	Subpart 483.70	,					
	-	•					
		2000 edition of the					
	National Fire Pr						
		FPA) 101, Life Safety					
	Code (LSC) and	410 IAC 16.2. The					
	original buildin	g was surveyed					
	with Chapter 19, Existing Health						
	Care Occupanc	•					
	This one story	facility was					
	<u>-</u>	=					
	uetermined to	be of Type V (111)					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

P1YW21

Facility ID:

002703

TITLE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION  01	(X3) DATE COMP			
		155680	A. BUILDING B. WING	-	09/01/2			
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2494 N LEBANON ST					
	OOD HEALTH CAM		LEBANON, IN46052					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
K0064 SS=F	The facility has with smoke det corridors reside spaces open to facility has the had a census of this survey.  Quality Review by I Code Specialist-Med  The facility was compliance with aforementioned requirements and a second point of the control	the corridors. The capacity for 55 and f 48 at the time of  Robert Booher, Life Safety dical Surveyor on 09/02/11.  If found not in h the dregulatory s evidenced by:  Guishers are provided in all ancies in accordance with S, NFPA 10 evation and acility failed to y inspections were of 9 portable fire NFPA 10, the ortable Fire in 4–4.1 requires	K0064	K 064  Submission of this p does not constitute a Homewood Health c wrong-doing or failu with the Federal or S Regulations.  Homewood Health C this plan of correction credible allegation are	n admission by campus of any are to comply State  Campus submits on as its letter of	09/17/2011		
	inspection. NF	-		a desk review or a re revisit immediately a 2011.				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

P1YW21 Facility ID: 002703

If continuation sheet Page 2 of 10

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 01 A. BUILDING 155680 09/01/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2494 N LEBANON ST HOMEWOOD HEALTH CAMPUS LEBANON, IN46052 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE of inspection and the initials of the Nine (9) of nine (9) portable fire person performing the inspection extinguishers were immediately shall be recorded. In addition inspected and initialed for the month NFPA 10, 4-2.1 defines inspection 09.1.11 for those residents found to have been affected by alleged as a quick check that an deficient practice. extinguisher is available and will operate. This deficient practice Nine (9) of nine (9) portable fire could affect affect all occupants. extinguishers were immediately inspected and initialed for the month 09.1.11 for those residents found to Findings include: have been affected by alleged deficient practice and for all Based on observations with the residents that may have the potential maintenance director on 09/01/11 to be affected. between 1:05 p.m. and 4:00 p.m., All extinguishers have been every portable fire extinguisher numbered and noted on a map, also had service and inspection tags a check list with approximate which noted the last monthly location has been constructed and check had been done 07/14/11. check list has been made that will require all portable fire extinguishers The maintenance director said at to be checked prior to the 15 th of the time of observation, he usually each month to ensure the alleged checked all the fire extinguishers deficient practice does not recur. when he conducted a fire drill and All fire extinguisjers will be checked had forgotten to do so. weekly times three (3) weeks After which they will be checked every 3.1 - 19(b)two weeks times two (2) Months then monthly and will be reviewed during Quality Assurance program monthly times six (6) months to ensure the deficient practice will not recur. All corrective actions will be completed by 09.17.2011.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

P1YW21

Facility ID:

002703 If continuation sheet

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 01 A. BUILDING 155680 09/01/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2494 N LEBANON ST HOMEWOOD HEALTH CAMPUS LEBANON, IN46052 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE Cooking facilities are protected in accordance K0069 19.3.2.6. NFPA 96 with 9.2.3. SS=D K 069 K0069 09/17/2011 Based on observation and interview, the facility failed to Submission of this plan of correction ensure 1 of 1 commercial cooking does not constitute an admission by extinguishing systems provided Homewood Health campus of any wrong-doing or failure to comply protection for the fryer in the with the Federal or State kitchen. NFPA 96, 7-1.2 requires Regulations. cooking equipment which produces grease laden vapors Homewood Health Campus submits such as, but not limited to, deep this plan of correction as its letter of credible allegation and is requesting fat fryers, ranges and tilt skillets a desk review or a request for a shall be protected by fire revisit immediately after October 1, extinguishing equipment. This 2011. deficient practice could affect 3 All kitchens cooking equipment was kitchen staff. immediately shifted to the proper spot to ensure the extinguishing Findings include: system coverage was being met on all cooking equipment which could have affect 3 kitchen staff. Based on observation of the commercial kitchen range hood All kitchens cooking equipment was protection system with the immediately shifted to the proper maintenance director on 09/01/11 spot to ensure the extinguishing at 2:35 p.m., protection was not system coverage was being met on all cooking equipment which could provided for the fryer since it was have affect 3 kitchen staff and of positioned out of the line of other residents having the potential protection near the very edge of to be affected by the same alleged the hood. An arm had been added deficient practice. to extend a nozzle of the Floor has been marked to ensure the extinguishing system over the fryer is always In the correct fryer, but it didn't reach because placement for ansil coverage and things had been moved. The check list constructed to ensure placement is being monitored to maintenance director said at the

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002703

If continuation sheet

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155680			(X2) M	(X2) MULTIPLE CONSTRUCTION  01		(X3) DATE SURVEY  COMPLETED		
			A. BUII B. WIN			09/01/2011		
NAME OF PROVIDER OR SUPPLIER HOMEWOOD HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE  2494 N LEBANON ST  LEBANON, IN46052					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
	time of observation, the fryer and other cooking appliances must have been moved.  3.1–19(b)  A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).  Survey Date: 09/01/11  Facility Number: 002703 Provider Number: 155680 AIM Number: 200309250  Surveyor: Bridget Brown, Life Safety Code Specialist  At this Life Safety Code survey, Homewood Health Campus was				ensure the alleged deficient practice does not recur.  The corrective measure will be monitored to ensure the alleged deficient practice does not recur by checking the location of the the extinguishing system to ensure there is coverage over all cooking equipment once daily times two (2) weeks then once weekly times six (6) months and will be reviewed during monthly Quality Assurance meetings.  All corrective actions will be completed by 09.17.2011			
K0000			K	K0000  Submission of this plan of correction does not constitute an admission by Homewood Health campus of any wrong-doing or failure to comply with the Federal or State Regulations.  Homewood Health Campus submits this plan of correction as its letter of credible allegation and is requesting a desk review or a request for a revisit immediately after October 1, 2011.		n by nny obly omits ter of sting		

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155680			A. BUILDING  B. WING			COMPI	COMPLETED 09/01/2011	
NAME OF PROVIDER OR SUPPLIER HOMEWOOD HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE  2494 N LEBANON ST  LEBANON, IN46052					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	CRO	PROVIDER'S PLAN OF CORRECTIO EACH CORRECTIVE ACTION SHOULD DSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
	Medicare/Medi Subpart 483.70 from Fire, the 2 National Fire Pr Association (NI Code (LSC), and The addition to March 2003 wa Chapter 18, Ne Occupancies.  This addition to determined to construction ar The facility has with smoke decorridors, resides spaces open to facility has the had a census of this survey.  The facility was compliance with aforementioned	for Participation in caid, 42 CFR D(a), Life Safety D(00) edition of the rotection FPA) 101, Life Safety d 410 IAC 16.2. The 300 hall after as surveyed with the Health Care To the 300 hall was be of Type V (111) The fully sprinklered. The alarm system tection in the lent rooms and the corridors. The capacity for 55 and f 48 at the time of						

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION (X3) DATE SURVEY		SURVEY
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUII	DING	02	COMPL	ETED
155680		155680	B. WIN			09/01/2	011
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER					LEBANON ST		
HOMEWOOD HEALTH CAMPUS			LEBANON, IN46052				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΤE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	177	TAG	DATE		
	· ·	ode Recertification	K	K0000 Submission of this plan of correction does not constitute an admission by			
	and State Licen	sure Survey was			Homewood Health campus of a	•	
	conducted by t	he Indiana State			wrong-doing or failure to compl		
	Department of	Health in			with the Federal or State	-	
	accordance wit	h 42 CFR 483.70(a).			Regulations.		
	Survey Date: 09/01/11				Homewood Health Campus sub this plan of correction as its lett credible allegation and is reque:	er of	
	Facility Number	r: 002703			a desk review or a request for a	-	
	Provider Numb				revisit immediately after Octob		
					2011.		
	AIM Number: 200309250 Surveyor: Bridget Brown, Life						
	Safety Code Sp	ecialist					
	Homewood Heafound not in co Requirements f Medicare/Medic	For Participation in caid, 42 CFR D(a), Life Safety D000 edition of the cotection EPA) 101, Life Safety d 410 IAC 16.2. The the 300 hall after as surveyed with					
	determined to	o the 300 hall was be of Type V (111) nd fully sprinklered.					

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUIL	DING	IG COMPLETED		
		155680	B. WINC			09/01/20	011
NAME OF B	DOMED OF GLIPPI IED			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER				2494 N	LEBANON ST		
HOMEW	OOD HEALTH CAM		LEBANON, IN46052				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL			ID PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG				PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			COMPLETION DATE
IAG		LSC IDENTIFYING INFORMATION)		IAG	BETTELET.		DATE
		a fire alarm system					
	with smoke de						
	corridors, resid						
		the corridors. The					
	<u>-</u>	capacity for 55 and					
	had a census o	f 48 at the time of					
	this survey.						
	The facility was	found not in					
	compliance wit						
	=						
	aforementioned regulatory requirements as evidenced by:						
K0064	Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1, NFPA 10. 18.3.5.6		1	İ			
SS=F							
			K0064		TZ 0.64		00/15/0011
	Based on obse		K0	064	K 064		09/17/2011
	interview, the f	acility failed to			Submission of this plan of corre	ction	
	ensure monthly checks were				does not constitute an admission		
	provided for 1	of 2 portable fire			Homewood Health campus of a	ny	
	extinguishers p	protecting the 300			wrong-doing or failure to compl	y	
	hall addition. I	NFPA 10, the			with the Federal or State		
	Standard for Po				Regulations.		
	Extinguishers.	in 4–4.1 requires			Homewood Health Campus sub	mits	
	fire extinguish	-			this plan of correction as its letter		
	-	aintenance when			credible allegation and is reques		
	-	icated by a monthly			a desk review or a request for a		
					revisit immediately after October 1,		
	inspection. NFPA 10, 4-2.2 defines maintenance as a				2011.		
	ueimes mainte	Hance as a					

FORM APPROVED OMB NO. 0938-0391

PRINTED:

09/16/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 02 A. BUILDING 155680 09/01/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2494 N LEBANON ST HOMEWOOD HEALTH CAMPUS LEBANON, IN46052 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE Nine (9) of nine (9) portable fire "thorough check" of the extinguishers were immediately extinguisher. It is intended to inspected and initialed for the month give maximum assurance the 09.1.11 for those residents found to extinguisher will operate have been affected by alleged deficient practice. effectively and safely. NFPA 10, 4-3.4.2 requires at least monthly, Nine (9) of nine (9) portable fire the date of inspection and the extinguishers were immediately initials of the person performing inspected and initialed for the month the inspection shall be recorded. 09.1.11 for those residents found to have been affected by alleged In addition NFPA 10, 4-2.1 defines deficient practice and for all inspection as a quick check an residents that may have the potential extinguisher is available and will to be affected. operate. This deficient practice All extinguishers have been could affect affect all occupants. numbered and noted on a map, also a check list with approximate Findings include: location has been constructed and check list has been made that will Based on observations with the require all portable fire extinguishers to be checked prior to the 15 th of maintenance director on 09/01/11 each month to ensure the alleged between 1:05 p.m. and 4:00 p.m., deficient practice does not recur. portable fire extinguishers located in the maintenance office and All fire extinguisiers will be checked weekly times three (3) weeks After corridor outside the maintenance which they will be checked every office were available to protect the two weeks times two (2) Months then 300 hall addition. The portable monthly and will be reviewed during fire extinguisher located in the Quality Assurance program monthly times six (6) months to ensure the corridor had a service and deficient practice will not recur. inspection tag which noted the last monthly check had been done All corrective actions will be 07/14/11. The maintenance completed by 09.17.2011. director said at the time of observation, he usually checked all the fire extinguishers when he

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/16/2011 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY					
COMPLETED 09/01/2011					
2494 N LEBANON ST LEBANON, IN46052					
PROVIDER'S PLAN OF CORRECTION					
ATE	COMPLETION				
	DATE				
	1				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

P1YW21 Facility ID:

ty ID: 002703

If continuation sheet

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